PAGE 01 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G161 07/16/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE **CHRYSALLIS** WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX 1D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) W 000 INITIAL COMMENTS W 000 On July 3, 2008 at approximately 10:15 PM the State Agency (SA) was notified Direct Care Counselor (DCC) #1 witnessed DCC#2 hit Client #1 at a nightclub. An onsite investigation was initiated on July 10, 2008 to verify compliance with federal regulatory requirements in the condition of Governing Body and Client Protection, During the investigation, the SA determined that the behavior/actions of the facility's House Manager (HM) and the lack of the facility to take appropriate actions resulted in abuse/neglect which posed a serious and immediate threat to Client #1. Client #2. Client #3. Client #4, Client #5 and Client #6's health and safety. The Chief Executive Officer/President was notified of the immediate jeopardy concerns on July 14, 2008 at approximately 3:30 PM. [ Note: SA surveyor remained at the facility until systems were in place to remove the immediate jeopardy. These systems included: terminating the House Manager immediately [July 14, 2008]; appointing the Qualified Mental Retardation Professional (QMRP) as temporary House Manager and hiring a new House Manager In answer to W 122, the facility trained on incident reporting and abuse/neglect. hereby cross-references and W 122 **483.420 CLIENT PROTECTIONS** adopts the responses to W 127, The facility must ensure that specific client W 149, W 155, W 156, and protections requirements are met. W 193 The Governing Body will more aggressively monitor the staff This CONDITION is not met as evidenced by: work performances and the Based on interview and record review the facility operations of the facility to failed toensure that systems were designed and prevent a repeat of the concerns implemented to ensure clients were not subjected in W.122 to physical abuse (Cross refer to W127); failed to LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE 8/15/08 President

CHRYSALLIS INC

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 09G161

08/18/2028 14:43

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PAGE 02 FORM APPROVED OMB NO. 0938-0391

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implement policies that ensure health and safety; (Cross refe protect clients from further pol an allegation of abuse was investigations to the administrate representative or to other offic with State Law within five work incident (Cross refer to W 156 demonstrate competency in in Behavior Support Plan (BSP) being investigated. (Client #1) W193)  The effects of these systemic in the failure of the facility to pensure their health and safety 483.420(a)(5) PROTECTION RIGHTS  The facility must ensure the righterefore, the facility must ennot subjected to physical, verificated to ensure that systems with the physical abuse or punish to physical abuse, for six of the resided in the facility. (Client #3, Client #4, Client #5 and Climber of the proximately 4:35PM revealed 2008 at approximately 8:00 Pleasers of the service with DCC #1 on July approximately 4:35PM revealed 2008 at approximately 8:00 Pleasers with the proximately 8:00 Pleasers with the prox	r to W149) failed to tential abuse while restigated; (Cross the results of all ator or designated sials in accordance king days of the sials of all client (Cross refer to practices resulted rotect its clients and OF CLIENTS  ghts of all clients, sure that clients are bal, sexual or inment.  as evidenced by: d review, the facility were designed and is were not subjected e six clients that stated that silent #6)  y 10, 2008 at ed that on July 3,	W 12	W 127  As answer to W 127, 6 says follows:  1. The behaviors and a the House Manager (I DCC #2 in the incider	actions of alm) and at of 7/03/08 altogether if alm and contrary to trainings, as of the ar was aed and allity on the areby are the areas areas areas are the ar	7/14/08

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W 127	nightclub, she witne eyeglasses off of D	essed Client #1 knock the CC #2 and then witnessed	W 127				
	across his face. DD the House Manager Interview with DCC approximately 2:45 allowed to ride back	pened hand to slap Client #1  C #1 immediately informed  r (HM) of the incident.  #1 on July 14, 2008 at  PM revealed that DCC #2 was  to the facility in the facility  and he remained on duty until  at 12 midnight.		3. A new House Manager was appointed on 710/2008 effectiv 7/16/2008. A copy of the letter appointing a new HM is hereby attached.	7/16/08		
	Telephone interview Retardation Profess 2008 at approximat July 3, 2008 at 9:00 the nightclub incide HM that DCC #2 ha had walked off the fatated that he inforresignation would not the state of the st	with the Qualified Mental sional (QMRP) on July 10, ely 5:30 PM revealed that on PM the HM informed him of hit. He was informed by the d turned in his resignation and facility's property. The QMRP ned the HM that DCC #2's ot stop the investigation and the Chief Executive Officer		4. The new HM is well trained and experienced in incident management and reporting.  5. Therefore there is no further threat of potential abuse to clie # 1, #2, #3, #4, #5, and #6 in th facility.  6. The QMRP will monitor supervise the new House mana to ensure quality services and performance.	nts		
	at approximately 12	with the HM on July 11, 2008 :35 PM revealed conformed cident as reported by both MRP.	·				
		th the HM revealed that DCC from employment on July 3.	•				
	2008 at approximat Incident Manageme informed him that D until the end of his : 2008. Further interv	with the QMRP on July 11, ely 4:30 PM revealed that the ent Coordinator (IMC) had ICC #2 had remained on duty shift at 12midnight on July 3, riew revealed that DCC #2 did like after July 3, 2008 but that it	•				

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W 127	Continued From pa	ge 3	W	27			
	could not be confirr on administrative le	ned when DCC #2 was placed ave.					
	approximately 2:30 placed on administrem physically abusing (hand to slap Client interview revealed to July 12, 2008, the	MC on July 14, 2008 at PM revealed that DCC #2 was rative leave on July 7, 2008 for Client #1 by using his opened #1 across his face. Further hat the QMRP was informed at DCC #2 had remained on his shift at 12 midnight on					
	approximately 3:00 knocked his eyegla #2 stated that he dislap Client #1 across attempted to stop C eyeglasses. DCC # the facility in the faculti the end of his review revealed that the HM on July 3, 2 on administrative le investigation regard DCC #2 stated that July 4-July 6, 2008, he had family in tow stated that he was 12008, by the IMC tr	#2 on July 14, 2008 at PM revealed that Client #1 sees off at the nightclub. DCC d not use his opened hand to see his face but merely client #1 from breaking his 2 stated that he rode back to cility van and remained on duty shift at 12 midnight. Further at DCC #2 was not informed by 008 that he was to be placed ave pending the results of the ling the allegation of abuse. The was scheduled to work on however he called in because on over the weekend. DCC #2 verbally informed on July 7, at he was on administrative esults of the investigation ation of abuse.					
	15, 2008 at approxi on July 3, 2008 at a the nightclub, also	f2 from another facility on July mately 5:00PM revealed that approximately 8:00 PM while at witnessed the incident #1. HM#2 immediately			·		

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NAME OF	PROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0771	16/2008
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W 127	informed the nighto witnessed physical	llub's security guard of the abuse. HM#2 also witnessed ient #1 out of the nightclub	W 1	27		
W 149	The SA determined was made aware the abused by DCC# 2 afrom further potentia #2 to remain on duty supervision to Client The SA determined the facility's House Mabuse/neglect which immediate threat to Client #4, Client #5 a safety. The Chief Exwas notified of the intermined of the intermined in July 14, 2008 at a Intermined in July 15, 2008 at a Intermined in July 16, 2008 at a Intermined in Ju	that the the House Manager at Client #1 was physically and did not protect Client #1 all harm. The HM allowed DCC to provide one to one #1.  that the behavior/actions of Manager (HM) resulted in posed a serious and Client #1, Client #2, Client #3, and Client #6's health and secutive Officer/President mediate jeopardy concerns approximately 3:30 PM.  ency surveyor remained until his in place to remove the by terminating the House y, appointing the Qualified Professional (QMRP) as anager and hiring a new ned on incident reporting and ive July 16, 2008.]  F TREATMENT OF  elop and implement written res that prohibit ct or abuse of the client.	W 14	As answer to W 149, the says follows:  1. The facility developed been implementing its incomanagement policy and procedures, but on 7/03/2 House Manager recklessly derailed the facility's incomanagement policies and procedures. The said House Manager's employment has terminated.  A new House Manager happointed and will continuing lement the facility's in management policies and procedures.  2. As further response to the facility hereby cross references the answers to and adopts same hereto.	and has ident  008, the y dent  se as been as been ue to ncident  W 149,	Ongoing 7/14/08 7/16/08
		not met as evidenced by: and record review, the				

08/18/2028 14:43 3018536756 DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ø<u>6</u>. PAGE CHRYSALLIS INC 08/18/2028 14:43 3018536756 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 07/16/2008 09G161 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3765 FIRST STREET, SE WASHINGTON, DC 20020 CHRYSALLIS PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 149 Continued From page 5 W 149 facility's House Manager (HM) failed to implement it's incident management protocol for one of one client in the investigation (Client #1). The finding includes: Interview and record review on July 14, 2008 at approximately 3:20 PM revealed that the House Manager did not follow the facility's incident management policy that required that any employee alleged to have committed any form of abuse or neglect be removed from duty. The HM allowed Direct Care Counselor (DCC) #2 to remain on duty to provide one to one supervision to Client #1. W 155 There was no evidence that the facility's House Manager implemented it's incident management policy. W 155 483.420(d)(3) STAFF TREATMENT OF As answer to 155, the facility W 155 says as follows: CLIENTS 1. The facility's House Manager The facility must prevent further potential abuse failed to remove the Direct Care while the investigation is in progress. Counselor # 2 from duty immediately as required by the This STANDARD is not met as evidenced by: facility's policies and procedures Based on interview and record review, the facility on 7/03/2008. The HM also failed to provide evidence that Client #1 was

FORM CMS-2567(02-99) Previous Versions Obsolete

The finding includes:

protected from further potential abuse while an

Cross refer to W127. Interview with Direct Care

Counselor #2 on July 14, 2008 at approximately 3:00 PM revealed that he rode back to the facility

in the facility van with Client #1 and remained on

duty until the end of his shift at 12 midnight.

allegation of abuse was investigated.

Event ID:Y3TW11

Facility IO: 09G161

misrepresented the facts to his

However, the HM's employment with facility has been terminated.

He has been removed from the

Manager has been appointed.

facility, and a new House

supervisors for reasons that

incomprehensible.

If continuation sheet Page 6 of 10

7/14/08

7/16/08

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W 155	Continued From pag	ge 6	W 15	5		
	Further review rever informed by the HM to be placed on adm results of the investi	aled that DCC #2 was not on July 3, 2008 that he was ninistrative leave pending the		W 156		
	however he called in town over the weeks was verbally informe Incident Management was on administrative	n July 4-July 6, 2008, because he had family in end. DCC #2 stated that he ed on July 7, 2008, by the nt Coordinator (IMC) that he e leave pending the results of arding the allegation of		As response to W 156, the says as follows:  1. The incident that was		
		PM revealed that he allowed a duty to provide one to one		investigated took place in p club that opens only on cer days. The internal investig could not be completed be of lack of access to a critic witness. The investigator h	tain ation cause al	
	witnessed DCC #2 e nightclub into the fac	on July 15, 2008 at I'M revealed that she also escot Client #1 out of the illity's van after the incident.		wait until a certain day whe club opens to provide servi The evidence of HM # 2 w critical to determination of case and this evidence was	ces. as the	
, .	Manager protected C	lient #1 from further an allegation of abuse was	W 156	obtained when the club ope and this placed the investig	ened ation	
:	to the administrator of	estigations must be reported or designated representative accordance with State law ays of the incident.		and the need to extend the secure the evidence of HM 2. However, the facility will endeavor to limit investiga	time to	ongoing
		not met as evidenced by: nd record review the facility		five days as stipulated in the		~*************************************

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		& MEDICAID SERVICES				OMB NO.	0938-0391
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W 156	Continued From pa	ge 7	W	156	W 189		
	failed to report the report the administrator or to other officials in a within five working of the finding includes. Review of the internal 8, 2008 at approximate incident occurred investigation was considered the internal in there was no evide investigation was rewithin five working of 483,430(e)(1) STAFT The facility must promitial and continuing employee to perform efficiently, and compare the facility facilit	esults of all investigations to designated representative or accordance with State Law days of the incident.  It all investigative report on July mately 1:31 PM revealed that if on July 3, 2008 and internal ampleted on July 16, 2008. The incident of the ported to the administrator myestigation on July 16, 2008. The ported to the administrator lays of the incident.  If TRAINING PROGRAM ovide each employee with a training that enables the material in the ported by:  In the incident of the material interview and record the interview and record the interview and record the employee to perform his orly, efficiently, and		189	As answer to W 189, the says as follows:  1. The House manager reeffective training on incide management policy and procedures as well as oth training requirements.  The House Manager malfunctioned and failed implement the policies as procedures as required. It contrary to his experience training and knowledge, employment was termina 7/14/08  2. The Direct Care Councilient # 1 received effect training on client # 1 Bel Support Plan and Incider management policy and procedures as well as oth training requirements. The said direct care staff malfunctioned and reckle failed to implement client BSP and policies and procedured. He acted construction in the said direct care staff malfunctioned and reckle failed to implement client BSP and policies and procedured. He acted constructions as required.	to to dient ter  to dient le acted e, His ted on selor to ive navior at  f essly ut # 1 pcedures	7/14/08
	effective training on policy ensuring that	se Manager had received their incident management clients were not subjected to an allegation of abuse was			his experience, training a knowledge. His employs terminated on 7/16/08	and	7/16/08

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W 189	Continued From page	ge 8	W 1	90		<u> </u>
	investigated.	3.0	** 11			1
	, Jan.					
		/193. The facility staff failed to				-
		Care Counselors received				
		demonstrate competency in ehavior Support Plan (BSP)		ŀ		1
	for Client #1.	shavor Support Flam (BSF)			;	
VV 193	]	F TRAINING PROGRAM	·W 19	93 W 193		
		o demonstrate the skills and				
		ry to administer interventions	-	As answer to w 193, the f	facility	}
	to manage the inapp	propriate behavior of clients.		says as follows:		
	Based on staff intervitie facility staff failed in implementation the	not met as evidenced by: views and record verification, d to demonstrate competency e Behavior Support Plan e client being investigated.		1. The Direct Care Couns client # 1 received effecti training on client # 1 Beh Support Plan and Inciden management policy and procedures as well as other	ve avior t	
	The finding includes:	:		training requirements.		
	2008, on July 9, 2008 revealed that Direct of witnessed DDC #2, strightclub.	l incident report dated July 3, 8 at approximately 6:00 PM Care Counselor (DDC) #1 smack Client #1 at the		2. The said direct care stated malfunctioned and reckle failed to demonstrate command skills in implementing # 1 BSP and policies and procedures as required.	ssly ipetency	6/4/8
	approximately 4:35P 2008 at approximate nightclub, she witnes #2's eyeglasses off a	C#1 on July 10, 2008 at I'M revealed that on July 3, By 8:00 PM while at the seed Client #1 knock DDC and that DDC #2 than used slap Client #1 across his face.		3. He acted contrary to his experience, training and knowledge. His employm terminated on 7/16/08		Ongoing
	approximately 3:00 F	C #2 on July 14, 2008 at Mrevealed that on July 3,-				

DEPARTMENT OF HEALTH AND HUMA CENTERS FOR MEDICARE & MEDICAL STATEMENT OF DEFICIENCIES (X1) PROVIDER			(X2) MU	CHRYSALLIS INC  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			PRINTED: 07/23/2008 FORM APPROVED OMB NO. 0938-039  (X3) DATE SURVEY COMPLETED  C	
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W 193	#2 stated that he dislap Client #1 across attempted to stop C eyeglasses by push c. Interview with oth investigation reveals approximately 8:00 Client #1 knocked DDC #2 then used I #1 across his face.  Review of Client #1 (BSP) dated Novem at approximately 6:0 behaviors that inclubitting, scratching, gobjects at others; cl room. Further revier for physical aggress to one to re-direct the provide neutral physical p	sses off at the nightclub. DDC d not use his opened hand to is his face but merely client #1 from breaking his ing Client #1 away.  Her staff witnesses during this ed that on July 3, 2008 at PM while at the nightclub, DDC #2's eyeglasses off and his opened hand to slap Client PM revealed targeted ded physical aggression, grabbing, pulling and throwing ients and staff and across the w revealed that interventions sion included "saying stop, one ne client to another area and sical/verbal contact to reduce tent."	W 15	93				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED	
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1 000	INITIAL COMMENT	S		1 000			
	State Agency (SA) v Counselor (DCC) #' Resident #1 at a nig investigation was iniverify compliance wi requirements in the and Client Protection the SA determined to the facility's House Note the facility to take ap abuse/neglect which	tiated on July 10, 200 ith federal regulatory condition of Governing. During the investighat the behavior/actionager (HM) and the propriate actions responsed a serious and	are  28 to  29 g Body  ation,  ons of  e lack of  sulted in				
. :	immediate threat to I Resident #3, Reside Resident #6's health Executive Officer/Pre immediate jeopardy ( approximately 3:30 F	nt #4, Resident #5 at and safety. The Chi esident was notified concerns on July 14,	nd lef of the				
	Note: SA surveyor resistems were in place in pla	e to remove the immems included: terminately [July 14, index mediately [July 14, index mediately ] as temporary Hous in new House Manage	nediate nating 2008]; on e				
1 500	3523.1 RESIDENT'S	RIGHTS		1 500			ĺ
1	Each GHMRP reside that the rights of reside protected in accordar chapter, and other apaws.	lents are observed a nce with D.C. Law 2-	ind 137, this				
1	This Statute is not m Each GHMRP reside		sure	:			
aith Regulat	ion Administration				TITLE	(	X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIO	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7,110	01 211	IDENTIFICATION NO.	MOCIN.	A. BUILDING	G	C	
		HFD03-0229		B. WING _		07/16/	/2008
NAME OF S	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRYSA			3765 FIRS WASHING	ST STREET, STON, DC 20	SE 0020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1 500	Continued From pa	ge 1		1500			-
	that the rights of resprotected in accordance chapter, and other alaws.	ance with D.C. Law 2	2-137, this				
	The finding includes	<b>5</b> !					
	Interview with DCC approximately 4:35F 2008 at approximate nightclub, she witne eyeglasses off of DC DCC #2 used his op #1 across his face. I the House Manager Interview with DCC approximately 2:45 was allowed to ride facility van with Res duty until the end of Telephone interview Retardation Profess 2008 at approximate July 3, 2008 at 9:00 the nightclub incider HM that DCC #2 hand had walked off QMRP stated that h #2's resignation wo and that he would no Officer (CEO) and officer (CEO) and officer (CEO) and officer interview at approximately 12	PM revealed that on aly 8:00 PM while at seed Resident #1 kn CC #2 and then with pened hand to slap R DDC #1 immediately (HM) of the incident #1 on July 14, 2008 PM revealed that DC back to the facility in ident #1 and he rem his shift at 12 midnificational (QMRP) on July 5:30 PM revealed with the Qualified M incomal (QMRP) on July 5:30 PM revealed turned in his resignation his resignation of the HM to the facility's property informed the HM to the Chief Executive relevant parties with the HM on July	July 3, the lock the lessed lesident informed it. at ICC #2 the leained on legit. If that on distribution in the leation lestigation letive it.		As answer to 1500, the farsays as follows:  1. The behaviors and active the House Manager (HM) DCC #2 in the incident of involving client #1 are altowery reprehensible and unconscionable. The HM DCC #2 chose to act con all their experiences, train policies and procedures of facility.  2. The House Manager we consequently terminated removed from the facility 7/14/2008. A copy of the termination letter is herebattached. Also the DCC # terminated and permanent removed from the facility the facility for the facilit	ons of and 7/03/08 cogether and atrary to nings, of the as and on by 42 was attly	7/14/08
·	the details of the ind DDC #1 and the QN Further interview with	ident as reported by IRP. th the HM reveal <del>e</del> d t	both	·	7/16/2008. A copy of the termination letter is herel attached.	· ·	7/16/08
	#2 was terminated f	rom employment on	July 3,				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			
		HFD03-0229		B. WING			0
NAME OF A	PROVIDER OR SUPPLIER	111-003-0223	STORET ADD	שבפפ רודי	STATE, ZIP CODE	07/1	6/2008
147-44-07-1							
CHRYSA	/rtis		WASHING	T STREET TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
l 500	Continued From page 2008.  Telephone interview 2008 at approximate Incident Managemeinformed him that Descriptions and page 100 per pag	with the QMRP on . ely 4:30 PM revealed nt Coordinator (IMC)	that the had	1 500			
	until the end of his s 2008. Further intervine work in the facility could not be confirm on administrative lease Interview with the IM approximately 2:30 F was placed on admin 2008 for physically a his opened hand to sface. Further interview as informed on July remained on duty unmidnight on July 3, 2	hift at 12midnight on ew revealed that DC by after July 3, 2008 to ed when DCC #2 waste.  C on July 14, 2008 a PM revealed that DC histrative leave on July 14 across revealed that the C y 12, 2008, that DCC till the end of his shift 008.	July 3, C # 2 did out that it as placed at C #2 ily 7, by using oss his QMRP # 2 had t at 12		3. A new House Manage appointed on 710/2008 e 7/16/2008. A copy of the appointing a new HM is attached. 4. The new HM is well to and experienced in incide management and reporting. 5. Therefore there is no fithreat of potential abuse the 1, #2, #3, #4, #5, and #facility. 6. The QMRP will monit supervise the new House	ffective letter hereby ained ent ag. urther to clients 6 in the	7/16/08
	Interview with DCC # approximately 3:00 F knocked his eyeglas: #2 stated that he did slap Client #1 across attempted to stop Re	PM revealed that Res ses off at the nightch not use his opened his face but merely	sident #1 ub. DCC hand to		to ensure quality services performance. Furthermore, to ensure the rights of the clients of the	and hat the facility	ongoing
	eyeglasses. DCC #2 the facility in the facility in the facil until the end of his streview revealed that the HM on July 3, 20 on administrative lear	stated that he rode I ity van and remained ift at 12 midnight. Fo DGC #2 was not info 08 that he was to be	pack to d on duty urther primed by placed		are observed and protecte required by law.	xi as	
	investigation regardir DCC #2 stated that h July 4-July 6, 2008, h he had family in town stated that he was ve 2008, by the IMC tha	ng the allegation of a le was scheduled to lowever he called in lover the weekend. I arbally informed on J	buse. work on because DCC #2 uly 7.				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0229			(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SU COMPLE			
NAME OF S	ROVIDER OR SUPPLIER	HED03-0423	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE				
CHRYSA			3765 FIRS	RST STREET, SE GTON, DC 20020					
(X4) ID PREFIX TAG	(6ACH DEFICIENCY	MUST BE PRECEDED BY	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
	(6ACH DEFICIENCY MUST BE PRECEDED BY FULL		1 500	DEFICIENC	(Y)				
	immediate jeopardy concerns on July 14, 2008 at approximately 3:30 PM.  [ Note: The State Agency surveyor remained until the facility put systems in place to remove the immediate jeopardy by terminating the House Manager immediately, appointing the Qualified Mental Retardation Professional (QMRP) as temporary House Manager and hiring a new House Manager trained on incident reporting and abuse/neglect effective July 16, 2008.]								
	1					<del></del>			

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